Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS235AGZ	A. BUILDING _____ B. WING _____	05/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN OF EDEN HOME CARE	4509 LILLIPUT LANE LAS VEGAS, NV 89102

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Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 5/15/09 and completed on 6/16/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons, and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was three. Three resident files were reviewed and two employee files. One discharged resident file was reviewed. The facility received a grade of D. Complaint #21860 was substantiated. See Tag Y50, Y53, Y826, Y850 and Y878. The following deficiencies were identified:	Y 000		
Y 050 SS=F	449.194(1) Administrator's Responsibilities-Oversight NAC 449.194 The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is	Y 050		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 050	Continued From page 1 in compliance with the requirements of NAC 449.156 to 449.2766, inclusive, and chapter 449 of NRS. This Regulation is not met as evidenced by: Based on observation, interview and record review on 5/15/09 and 5/22/09, the administrator failed to provide oversight and direction to the staff to ensure 3 of 3 residents receive the needed services and protective supervision they required. Refer to Tags Y053, Y070, Y103, Y515, Y878 and Y923. Severity: 2 Scope: 3	Y 050		
Y 053 SS=F	449.194(4) Administrator's Responsibilities-Complete Rec NAC 449.194 The administrator of a residential facility shall: 4. Ensure that the records of the facility are complete and accurate. This Regulation is not met as evidenced by: Based on observation, interview and record review on 5/15/09 and 5/22/09, the administrator failed to keep the records of the facility complete and accurate:	Y 053		

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Y 053	Continued From page 2 - The Medication Administration Record (MAR) for Resident #1 had no initials documented indicating medications were administered from 5/6/09-5/10/09. - A copy was requested of the MAR and provided by the owner. The copy of Resident #1's MAR showed initials through 5/14/09, but he was admitted to the hospital on 5/10/09. - On 5/22/09, the caregiver reported he administered medication to the residents and the owner initialed the MARs when she arrived at the facility because he had not attended medication training. Severity: 2 Scope: 3	Y 053		
Y 072 SS=F	449.196(3) Qualications of Caregiver-Med Training NAC 449.196 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Receive, in addition to the training required pursuant to NRS 449.037, at least 3 hours of training in the management of medication. The caregiver must receive the training at least every 3 years and provide the residential facility with satisfactory evidence of the content of the training and his attendance at the training; and (b) At least every 3 years, pass an examination relating to the management of medication approved by the Bureau.	Y 072		

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Y 072	Continued From page 3 This Regulation is not met as evidenced by: Based on interview and record review on 5/15/09 and 5/22/09, the facility failed to ensure that 1 of 2 caregivers completed the required initial medication management training. (Employee #2). Severity: 2 Scope: 3	Y 072		
Y 103 SS=F	449.200(1)(d) Personnel File - NAC 441A NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee. This Regulation is not met as evidenced by: Based on record review on 5/15/09, the facility failed to ensure 1 of 2 caregivers complied with NAC 441A.375 regarding pre-employment physical examinations for the protection of all residents (Employee #2). Severity: 2 Scope: 3	Y 103		
Y 826 SS=D	449.2734(3) pressure or stasis ulcers NAC 449.2734 3. The administrator of the facility shall ensure that records of the care provided to a person who has a pressure or stasis ulcer pursuant to subsection 2 are maintained at the facility. The	Y 826		

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Y 826	Continued From page 4 records must include an explanation of the cause of the pressure or stasis ulcer. This Regulation is not met as evidenced by: Based on record review and interviews on 5/22/09, the facility failed to identify a Stage I pressure ulcer on 1 of 4 residents (Resident #1). Refer to Tag Y850. Severity: 2 Scope: 1	Y 826		
Y 850 SS=G	449.274(1)(a) Medical Care of Resident NAC 449.274 1. If a resident of a residential facility becomes ill or is injured, the resident's physician and a member of the resident's family must be notified at the onset of the illness or at the time of the injury. The facility shall: (a) Make all necessary arrangements to secure the services of a licensed physician to treat the resident is the resident's physician is not available. This Regulation is not met as evidenced by: Based on interview and record review from 5/15/09 to 5/28/09, the facility failed to secure the services of a licensed physician to treat 1 of 4	Y 850		

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Y 850	Continued From page 5 residents (Resident #1). Findings include: Resident #1 was admitted to the facility on 4/13/09 with diagnoses including dementia, mood disorder, diabetes mellitus, hypertension and atrial fibrillation. The resident was 87 years old. A review of Resident #1's medical file revealed his physician changed his dose of Glyburide on 4/14/09 from two and one-half tablets a day to two tablets in the morning and one tablet in the evening. The resident's physician also changed the dose his Metformin from 500 milligrams two times a day to 1000 milligrams two times a day with meals. Glyburide and Metformin are medications used to lower the glucose level in patients with type 2 non-insulin diabetes. Review of Resident #1's Medication Administration Record (MAR) on 5/15/09 revealed the facility had not changed the prescription orders for Glyburide and Metformin in the May 2009 MAR to match the physician's orders of 4/14/09. The resident's medications were observed to have been pre-poured into a small plastic pill cup. The amount of Glyburide and Metformin in the cup did not match the 4/14/09 physician's order. The facility was not giving the resident the amount of diabetic medication prescribed by his physician. (See Tag 878) A facility incident report indicated Resident #1 fell in his bedroom at 4:00 PM on 5/10/09. During an interview on 5/15/09, the owner of the facility reported the caregiver, Employee #1, called to tell her the resident fell sometime before dinner. When the owner arrived at the facility, the	Y 850		

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Y 850	Continued From page 6 resident was lying down and not complaining of pain but she noticed the resident's shoulder was swollen. She stated she told the caregiver to rub Icy Hot on the resident ' s shoulder. The owner acknowledged Resident #1 was provided his dinner meal in bed as she did not want him to fall again. The facility ' s incident report it was indicated the owner rubbed more Icy Hot on Resident #1 ' s shoulder at 7:00 PM. The owner documented in the report that the resident said he was okay and that the owner told him they would check his shoulder in the morning. But during the interview on 5/15/09, the owner stated she became worried that the resident's shoulder was swelling more and the resident was grimacing so she called 911. The owner stated she was concerned the resident may not be able to sleep because of the pain and she did not want to have to send the resident to the hospital in the middle of the night. Resident #2 was Resident #1 ' s roommate and was listed as a witness to the fall. Resident #2 reported he was not sure the exact time of the fall, but he felt it was around 1:30 AM Sunday morning and it was still dark. He stated Resident #1 fell when he got up from bed to go to the bathroom. Resident #2 reported he picked up Resident #1 and placed on the chair by his bed. He thought Resident #1's shoulder may have been dislocated. Resident #2 reported he was unable to call for help because the owner takes the phone out of the facility at night and the employee working, Employee #2, had his bedroom door locked. Resident #2 reported that Resident #1 sat in the chair the rest of the night and was moaning. He stated he was not sure what time Resident #1 was taken to the hospital.	Y 850		

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Y 850	Continued From page 7 The ambulance records indicated a call was received from the facility for a transportation request for Resident #1 at 9:21 PM on Sunday, 5/10/09. The physician's notes indicated the resident suffered a left humerus bone (upper arm) fracture. The Registered Nurse wrote that the patient was communicating his needs to staff, was slightly confused but answered questions with much thought and got the answers correct. The hospital records also indicated the resident's blood glucose level was measured at over 500 when he was admitted at 10:52 PM, and was at 745 at 11:30 PM, (normal is 70-110). The hospital records for Resident #1 indicated he reported to nursing staff on 5/11/09 that he fell on Saturday and hit the dresser in his room. A wound assessment done on 5/11/09 found a right buttock wound measuring 1.5 length by .5 width (Stage I) and blistering of the skin on the resident ' s left shoulder. The wife of Resident #1 related in an interview that the resident also told her he got up at night and fell against a bureau in his room. She reported he told her he laid there for a long time and did not go to the hospital until the morning. Resident #1 was transferred to a rehabilitation facility on 5/15/09. An attempt to interview the resident was made on 5/22/09 . The resident was unresponsive. Multiple interviews with the wife of the resident have occurred. The wife indicated the physician had talked to her about placing her husband on hospice because he was non-responsive and his health was declining. Severity: 3 Scope: 1	Y 850		
Y 878 SS=J	449.2742(6)(a)(1) Medication / Change order	Y 878		

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Y 878	Continued From page 8 NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This Regulation is not met as evidenced by: Based on observation, interview and record review 5/15/09 to 5/28/09, the facility failed to ensure that 1 of 4 residents received medications as prescribed (Resident #1). Findings include: Resident #1, an 87 year-old male, was admitted to the facility on 4/13/09 with diagnoses including dementia, mood disorder, diabetes mellitus, hypertension and atrial fibrillation. A review of Resident #1 file revealed his physician made changes to his medication regimen on 4/14/09. The physician discontinued potassium chloride, calcium and Lomotil. The physician also changed the dose of the resident ' s Glyburide from two and one half tablets a day to two tablets in the morning and one tablet in the evening; and the dose of Metformin from 500 milligrams (mg) two times a day to 1000 mg two times a day with meals. Both Glyburide and Metformin are medications used to lower the glucose level in patients with type 2 non-insulin diabetes.	Y 878		

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Y 878	Continued From page 9 A home health agency nurse began visiting the resident at the facility for blood sugar testing and medication management on 4/16/09. The resident's blood sugar was documented at 375 during this visit. Records provided by the home health agency showed the nurse provided follow up visits on 4/21, 4/23, 4/28, 4/30 and 5/4/09 for Resident #1 and his blood sugars ranged from 106 - 130. Resident #1 fell at the facility and was transported to the hospital at 9:50 PM on Sunday, 5/10/09. He was admitted to the emergency room at 10:36 PM. His blood sugar was tested at 10:52 PM and it measured greater than 500 and was repeated by the nurse. The nurse wrote in the medical record that the resident was able to communicate his needs to the staff, that the resident was slightly confused but was able to answered questions after much thought and got the answers correct. The resident ' s blood glucose was drawn at 11:30 PM and was documented as 745, much higher than the 106-130 range of reading by the home health agency. The resident was admitted to the hospital and his wife was called on Monday, 5/11/09, at 8:00 AM. The wife reported the facility had not called her to let her know her husband had fallen. On 5/11/09 at 9:00 AM, the resident was able to tell the nurse that he fell in the facility on Saturday and hit the dresser in his room. During the survey on 5/15/09, Resident #1 ' s May 2009 MAR did not reflect the 4/14/09 order changes for Glyburide and Metformin, and the three discontinued medication were documented as still being given. Resident #1's medications were pre-poured in cups and the cup with his name on it contained	Y 878		

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Y 878	Continued From page 10 potassium chloride, calcium, Lomotil; one tablet of Glyburide in the morning instead of two and one tablet of 500 mg. Metformin in the morning instead of two. The owner indicated these were the residents medications. She was saving them since he was in the hospital. The facility failed to follow Resident #1 ' s 4/14/09 physician medication orders for the 30 days prior to his fall at the facility and his blood sugar level had not been measured for six days prior to the fall. Resident #1 ' s health declined at the hospital and he was transferred to a rehabilitation facility where has become non-responsive, had a gastrostomy tube inserted for feeding due to malnutrition and may be put on hospice. This was a repeat deficiency from the 10/16/08 State Licensure survey. Severity: 4 Scope: 1	Y 878		
Y 923 SS=F	449.2748(3)(b) Medication Container NAC 449.2748 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (b) Kept in its original container until it is administered. This Regulation is not met as evidenced by:	Y 923		

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Y 923	Continued From page 11 Based on observation on 5/15/09 and 5/22/09, the facility failed to keep medications belonging to 3 of 3 residents in their original container (Resident #2, #3 and #4). The medications were set-up in individual plastic pill cups by the caregiver a head of time. Severity: 2 Scope: 3	Y 923		